Janet Napolitano, Governor
Anthony D. Rodgers, Director

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AHCCCS

Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Provider Address Update Form

(Completed W-9 Must Be Included)

NAME (Last, First, M.I.): _____ NPI # _____

AHCCCS PROVIDER ID#: _____ SOCIAL SECURITY #: _____

CHECK ONE: ☐ **ADD ADDITIONAL INFORMATION**
☐ **REPLACE EXISTING INFORMATION**

NOTE: Form will be returned if not completed.

CORRESPONDENCE ADDRESS

STREET LINE #1: _____

STREET LINE #2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: _____ _____ _____ EMERGENCY PHONE: _____ _____ _____

ATTENTION TO: _____

PAY-TO ADDRESS (SITE 01)

STREET LINE #1: _____

STREET LINE #2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: _____ _____ _____ EMERGENCY PHONE: _____ _____ _____

ATTENTION TO: _____

EMPLOYER TAX ID# _____ BEGIN DATE: _____ END DATE: _____

SERVICE ADDRESS (SITE 01) *Must be a Street Address*

STREET LINE #1: _____

STREET LINE #2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: _____ _____ _____ EMERGENCY PHONE: _____ _____ _____

FAX PHONE: _____ _____ ATTENTION TO: _____

BEGIN DATE: _____ END DATE: _____ PAY-TO LOC. CODE:* _____

(*=Please indicate the locator code for the pay-to address that applies to this service address.)

I affirm under penalty of law that the information on this form is true, accurate, and complete to the best of my knowledge.

SIGNATURE:** _____ TITLE: _____ DATE: _____

Must be signature of Provider or Authorized Signor on file with AHCCCS

Reset Form

PAY-TO ADDRESS (SITE 02)

STREET LINE #1:

STREET LINE #2:

CITY: STATE: ZIP:

BUSINESS PHONE: EMERGENCY PHONE:

ATTENTION TO:

EMPLOYER TAX ID# BEGIN DATE: END DATE:

SERVICE ADDRESS (SITE 02) *Must be a Street Address*

STREET LINE #1:

STREET LINE #2:

CITY: STATE: ZIP:

BUSINESS PHONE: EMERGENCY PHONE:

FAX PHONE: ATTENTION TO:

BEGIN DATE: END DATE: PAY-TO LOC. CODE:*

(*=Please indicate the locator code for the pay-to address that applies to this service address.)

PAY-TO ADDRESS (SITE 03)

STREET LINE #1:

STREET LINE #2:

CITY: STATE: ZIP:

BUSINESS PHONE: EMERGENCY PHONE:

ATTENTION TO:

EMPLOYER TAX ID# BEGIN DATE: END DATE:

SERVICE ADDRESS (SITE 03) *Must be a Street Address*

STREET LINE #1:

STREET LINE #2:

CITY: STATE: ZIP:

BUSINESS PHONE: EMERGENCY PHONE:

FAX PHONE: ATTENTION TO:

BEGIN DATE: END DATE: PAY-TO LOC. CODE:*

(*=Please indicate the locator code for the pay-to address that applies to this service address.)

I affirm under penalty of law that the information on this form is true, accurate, and complete to the best of my knowledge.

SIGNATURE:** TITLE: DATE:

***Must be signature of Provider or Authorized Signor on file with AHCCCS*

Reset Form